MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95-C

CERTIFICATE OF DEATH

04295 Reg. Dist. No. 330

1. PLACE OF DEATH:
County Wicomico
City or town Mardela Springs
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Mardela Springs
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME P. Jane Adams

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife John J. Adams
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) August 13, 1859

8. AGE: Years	Months	Days	If less than one day
85	7	29	...hrs. ...min.

9. Birthplace Wicomico County, Maryland (Town, county, and state)
10. Usual occupation Housework
11. Industry or business Home
FATHER 12. Name Washington J. Bradley
13. Birthplace Wicomico County, Maryland
MOTHER 14. Maiden name Sarah Elizabeth English
15. Birthplace Wicomico County, Maryland
16. Informant Mrs. Lizzie Calloway
Address Mardela Springs, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 14 1945 (month) (day) (year)
Cemetery or crematory Mardela Springs Methodist Cemetery
Location Mardela Springs, Maryland
18. Funeral director J. J. Frampton and Son
Address Federalsburg, Maryland
19. 4/14/45 (Date rec'd by registrar) W. H. Robertson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1945, at 10:30 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...1939... to Apr. ...1945...
and that I last saw h... alive on Apr. 17 1945
Immediate cause of death Cardiac Asthenia — DURATION
Due to Hemiplegia & Angina
Due to —
Other conditions None
(Include pregnancy within 3 months of death)
Major findings of operations —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE Frank Quinn M. D. or other
Address Mardela, Md. Date signed Apr. 17, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

04296

CERTIFICATE OF DEATH

Reg. Dist. No. 333

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: Wicomico
County
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months
Hospital, institution or street address where death occurred: P. S. Hoyt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 705 Poplar Hill ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Rebecca Painter Bauman
3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: William M. Bauman
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): April 15 1874

8. AGE: Years: 71 | Months: 0 | Days: 6 | If less than one day: hrs. min.

9. Birthplace: Reading, Pa.
(Town, county, and state)
10. Usual occupation: Home work at Home
11. Industry or business:
FATHER 12. Name: Enoch Painter
13. Birthplace: Berks Co. Pa.
MOTHER 14. Maiden name: Charlotte Phillipi
15. Birthplace: Berks Co. Pa.
16. Informant: Mrs. Miriam M. Emrich
Address: 705 Poplar Hill ave. Salisbury Md.
17. Burial (Burial, cremation, or removal. Which): Date thereof: April 25-45 (month) (day) (year)
Cemetery or crematory: Charles Evans Cem.
Location: Reading, Pa.
18. Funeral director: Holloway & C. Walter R. Holloway
Address: Salisbury Maryland.
19. 4/23/45 (Date received by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 21 1945 at 11.25 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1945 to Apr. 21 1945
and that I last saw h[illegible] alive on Apr. 21 1945

DURATION

Immediate cause of death: Acute Pulmonary Edema
Due to: Arteriosclerosis
Due to:
Other conditions: none
(Include pregnancy within 3 months of death)
Major findings of operations: none
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?
23. SIGNATURE: J. Rivers Hanson, M.D.
M. D. or other
Address: Salisbury Md. Date signed: 4/22/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

04297

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, Institution, or street address where death occurred:
John B. Parsons Home
How long in hospital or institution? 5 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mallie Beale

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Thomas H Beale
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 7, 1864

8. AGE: Years	Months	Days	If less than one day
80	9	19	..... hrs. ..... min.

9. Birthplace: Somerset Co, Md
(Town, county, and state)
10. Usual occupation: none
11. Industry or business:
FATHER 12. Name: Long
13. Birthplace: Somerset Co, Md
MOTHER 14. Maiden name: Susan
15. Birthplace: Somerset Co, Md
16. Informant: John B. Parsons Home
Address: Salisbury, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/28/45 (month) (day) (year)
Cemetery or crematory: Baptist cemetery
Location: Rockawalkin Maryland
18. Funeral director: Hill & Johnson
Address: Salisbury, Md
19. 4/28/45 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26, 1945 at 6 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1945 to Apr 26 1945
and that I last saw her alive on Apr 26 1945

Immediate cause of death	DURATION
Cardiac Thrombosis	2 hrs
Due to: Coronary Thrombosis	6 mos
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury: ..... Injured at work?

23. SIGNATURE: M. Lacy M.D.
M. D. or other
Address: ..... Date signed: 4/27/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9th)

04298

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 11 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: New York County:
City or town: New York
(If outside city or town limits, write RURAL and give nearest town)
Street No. 405 E. 140 St. Bronx 55 New York N.Y.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Isidor Berout

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Antonette Berout
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Oct. 13 - 1881

8. AGE:

Years	Months	Days	If less than one day
63	6	4	hrs. min.

9. Birthplace: Russia (Town, county, and state)
10. Usual occupation: Unknown Soc. Sec. # 087-05-5540
11. Industry or business: Unknown

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Mrs. Antonette Berout
Address: 405 E. 140 St. Bronx N.Y.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 19-1945 (month) (day) (year)
Cemetery or crematory: Fern Cliff Cem.
Location: Ardsley N.Y.

18. Funeral director: Hollowell & Walter R. Hollowell
Address: Salisbury Maryland.

19. 4/17/1945 (Date rec'd by registrar) Harriet E. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 17, 1945, at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Apr. 16 1945 to Apr. 17 1945 and that I last saw h. i. m. alive on Apr. 17 1945

Immediate cause of death	DURATION
CORONARY Occlusion	
Due to: CORONARY Sclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: D. Rivers Hanson, M.D.
M. D. or other
Address: Salisbury, Md. Date signed: 4/17/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

04299

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 922

CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 34 years
Hospital, institution, or street address where death occurred: 109 Edgewood St.
How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 109 Edgewood St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Estella Bond

3. (b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Andrew C. Bond
6.(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): Feb. 1, 1868.

8. AGE:

Years	Months	Days	If less than one day
77	2	15	...hrs. ...min.

9. Birthplace: Mt. Vernon, Somerset, Md.
(Town, county, and state)
10. Usual occupation: At Home ✓
11. Industry or business:

FATHER
12. Name: Samuel Kilbrey
13. Birthplace: Somerset Co. Md.

MOTHER
14. Maiden name: Elizabeth Hilkins
15. Birthplace: Virginia

16. Informant: Mrs. Kate Rees
Address: Salisbury, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/18/45 (month) (day) (year)
Cemetery or crematory: John Hurley
Location: Mt. Vernon, Md.
18. Funeral director: Geo. Hill & Johnson Co.
Address: Salisbury, Md.
19. 4/18/45 (Date rec'd by registrar) Harriet E. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16, 1945 at 8.30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 27, 1944 to April 16, 1945 and that I last saw h.e alive on April 14, 1945

Immediate cause of death: Valvular Heart Disease — DURATION: 10 yrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Thos. R. Mann M. D. or other
Address: Quantico Md Date signed 4/17/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 946

CERTIFICATE OF DEATH

04300

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 56 years
Hospital, Institution, or street address where death occurred: 110 E Williams
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 110 E Williams St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: William H Bounds

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bessie T. Bounds
6.(c) If alive, give age: 65 years
7. Birth date of deceased (mo., day, yr.): July 8 1858

8. AGE: Years: 86 Months: 8 Days: 26 If less than one day: hrs. min.

9. Birthplace: Somerset Co. Md (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Contractor

MOTHER FATHER
12. Name: John Bounds
13. Birthplace: Somerset Co. Md
14. Maiden name: Laura Lankford
15. Birthplace: Somerset Co. Md

16. Informant: Mrs W. H. Bounds
Address: Salisbury, Md.
17. Burial (Burial, cremation, or removal) Which? Date thereof 4/5/45 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury Md
18. Funeral director: Hill & Johnson Co.
Address: Salisbury Md
19. 4/6/1945 Harriet E. Johnson Funeral Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3, 1945 at 5 15 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/3 1945 to 5/3 1945 and that I last saw him alive on 5/3 1945

Immediate cause of death	DURATION
(a) Coronary Occlusion	Immediate
Due to (b)	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Rivers Hanson M.D.
M. D. or other
Address: Salisbury, Md. Date signed 4/5/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

64301

Reg. Dist. No. 323

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Tyaskin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Hargis Brown

3.(b) Social Security Number: 213-14-6510

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col.	Married

6.(b) Name of husband or wife: Emma Brown
6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): Mar 17 1904

8. AGE: Years	Months	Days	If less than one day
41	0	27	hrs. min.

9. Birthplace: Tyaskin, Wicomico, Md. (Town, county, and state)
10. Usual occupation: Cutting Timber
11. Industry or business: Wood Use Harland Harper

FATHER
12. Name: James Brown
13. Birthplace: Wiliquin Md

MOTHER
14. Maiden name: Lenila Hackett
15. Birthplace: Cambridge Md

16. Informant: Emma L Brown
Address: Hartford, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 17 1945 (month) (day) (year)
Cemetery or crematory: Tyaskin Md
Location: Tyaskin Col. Church
18. Funeral director: Harold Messick & Sons
Address: Parsons Md

19. 4/17/45 (Date rec'd by registrar) 19 Margie D. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 15, 1945, at 2:25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 30 1945 to Apr. 15 1945
and that I last saw h... alive on Apr. 15 1945

Immediate cause of death	DURATION
Acute Cardiac Failure	
Due to: Pneumococcic Meningitis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: A. Rivers Hanson, M.D.
M. D. or other
Address: Salisbury, Md. Date signed 4/15/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04302

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Two months

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: no

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Willie J. Brown

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a.a.	Single

6.(b) Name of husband or wife: no

6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): Jan 19 1946

8. AGE:

Years	Months	Days	If less than one day
	2	27	hrs. min.

9. Birthplace: Salisbury Md (Town, county, and state)

10. Usual occupation: no

11. Industry or business: no

FATHER

12. Name: Willie J. Brown

13. Birthplace: Peachers, N. C.

MOTHER

14. Maiden name: Francis Fields

15. Birthplace: Salisbury Md

16. Informant: Frances Fields

Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 20-1945 (month) (day) (year)

Cemetery or crematory: Hanton

Location: Salisbury Md

18. Funeral director: James P. Stewart

Address: Salisbury Md

19. Apr 20, 1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16, 1945, at 4 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 9, 1945 to Apr 16 1945 and that I last saw him alive on April 16 1945

Immediate cause of death	DURATION
Broncho Pneumonia	3 days
Due to:	
Bronchitis	4 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: G. H. Crumbley M.D. (M. D. or other)

Address: Salisbury Md Date signed: 4-20-1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94

04303

CERTIFICATE OF DEATH

Reg. Dist. No. 333

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred: Central Hotel

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For nonresidents give residence of mother)

State Md. County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. Central Hotel

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Grace S. Deibert

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Ezra Deibert

6.(c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) March 18-1884

8. AGE:

Years	Months	Days	If less than one day
61	1	4	hrs. min.

9. Birthplace Danville Pa.

(Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business

FATHER 12. Name Louis W. Deibert

13. Birthplace Pa.

MOTHER 14. Maiden name Nettie Lynn

15. Birthplace Pa.

16. Informant James Baird

Address 249 Lexington Ave. Sunbury Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 26-45 (month) (day) (year)

Cemetery or crematory North West Cem.

Location Sunbury Pa.

18. Funeral director Hellman & Co Walter R. Hellman

Address Salisbury Maryland.

19. 4/23, 1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 — 1945 at 10 — a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 to April 22 1945; and that I last saw h alive on April 22 1945

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lt Rodemeyer MC Deputy Med Examiner Wicomico Co

M. D. or other

Address Salisbury Md Date signed 4/23/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04304

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred: P.S. Hospt.
How long in hospital or institution? 3 hrs 20 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. Rural Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Marion Louis Disharoon

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): June 26th. 1895

8. AGE: Years: 49 | Months: 9 | Days: 5 | If less than one day: hrs. min.

9. Birthplace: Salisbury Maryland
(Town, county, and state)
10. Usual occupation: Butcher
11. Industry or business:

FATHER
12. Name: J. Day Disharoon
13. Birthplace: Friendland Md.

MOTHER
14. Maiden name: Alice F. Dawson
15. Birthplace: R.D. Georgetown Del.

16. Informant: Mrs. M. Arthur Disharoon
Address: 11. Wood St. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 4, 1945 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland

18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Maryland.

19. 4/4/45 (Date rec'd by registrar) 1945 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 1st 1945, at 7 10 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19... to ... 19... and that I last saw alive on ... 19...

	DURATION
Immediate cause of death: Fractured Skull	4 hrs
Due to:	
Due to:	
Other conditions: Co. Fracture left leg Bruises & Lacerations Scalp, head	4 hrs.

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident ? Date of 4-1-45
Where did injury occur? Salisbury (City or town) Wicomico (County) Md. (State)
Injured at home, farm, industry, public place (where?): street
Means of injury: Hit by motor vehicle driven by unknown negro Injured at work? No

23. SIGNATURE: Clarence O. Disharoon M.D.
Address: Salisbury, Md. Date signed 4/2/45

M. D. or other

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37-01)

CERTIFICATE OF DEATH

04395

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wyoming

City or town: Lakeburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life time

Hospital, institution, or street address where death occurred: Pensacola General Hospital

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Virginia County: Accomac

City or town: Bloxom (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Charles Warren Nock

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Georgie Nock

7. Birth date of deceased (mo., day, yr.): February 19, 1864 6.(c) If alive, give age ..... years

8. AGE: Years: 81 years | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Bloxom, Va (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER 12. Name: Isaac J. Nock

FATHER 13. Birthplace: Accomac County Va.

MOTHER 14. Maiden name: Jennie Bloxom

MOTHER 15. Birthplace: Accomac County, Va.

16. Informant: Mrs Georgie Nock

Address: Bloxom, Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 4 1945 (month) (day) (year)

Cemetery or crematory: Mapleville Cemetery

Location: Mapleville Va

18. Funeral director: John W. Johnson Inc.

Address: Parksley, Va.

19. 4/3 1945 (Date rec'd by registrar) Harriet E. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2, 1945, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22 1945 to April 2 1945 and that I last saw h--- alive on April 2 1945

Immediate cause of death	DURATION
Cer. Hemorrhage	Hours
Due to: Hypertensive Heart Disease	Yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Hypertensive Heart Dis

Date of op. Mar. 24, 1945

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ✓ Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. M. Nock M. D. or other

Address: Salisbury Date signed: 4/2/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Callie Dixon

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18a)

CERTIFICATE OF DEATH

04306

Reg. Dist. No. 232

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: no.

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Broad St No number

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Callie Dixon

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a a	no

6.(b) Name of husband or wife: no

6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): about 1903

8. AGE: Years: about 70 | Months: | Days: | If less than one day: ... hrs. ... min.

9. Birthplace: Salisbury Md (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Same

FATHER — 12. Name: Ernest Dixon

FATHER — 13. Birthplace: Snowhill

MOTHER — 14. Maiden name: Millie Price

MOTHER — 15. Birthplace: Snowhill

16. Informant: Priscilla Dixon

Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 18 1946 (month) (day) (year)

Cemetery or crematory: Hanston

Location: Salisbury Md

18. Funeral director: James F. & C. Stewart

Address: Salisbury Md

19. (Date rec'd by registrar) 4/18, 1946 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15 1946, at 9P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 26 1944 to April 14, 1946 and that I last saw h... alive on April 14, 1946

Immediate cause of death	DURATION
Due to: M. G. & Cardiac	3 months
Due to: Hypertension	?
Other conditions: Nephritis	?

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: J. H. Hearn M.D.

M. D. or other

Address: Salisbury Md Date signed: 4/18/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

04397

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH:

County: Wicomico

City or town: Westfingum md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 42 years

Hospital, Institution, or street address where death occurred: no

How long in hospital or Institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Westfingum md
(If outside city or town limits, write RURAL and give nearest town)

Street No.: no
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Rufus Dutton

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a.a.	Married

6.(b) Name of husband or wife: Mary Dutton

6.(c) If alive, give age: yes (Married from) years

7. Birth date of deceased (mo., day, yr.): Mar 28 about 1891

8. AGE: Years	Months	Days	If less than one day
54	—	—	..... hrs. ..... min.

9. Birthplace: Somerset Co
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Same

MOTHER

12. Name: Lee Dutton

FATHER

13. Birthplace: Somerset Co

MOTHER

14. Maiden name: Hester Jane

15. Birthplace: Westfingum md

16. Informant: Mrs Mary Dutton

Address: Westfingum md

17. Buried (Burial, cremation, or removal. Which?) Date thereof Apr 22 - 1945 (month) (day) (year)

Cemetery or crematory: Odd Fellows

Location: Westfingum md

18. Funeral director: James T. Stewart

Address: Salisbury md

19. Apr 22 1945 (Date rec'd by registrar) P. Wayford Walter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20th 1945, at 4.20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 30th 1945 to April 20th 1945 and that I last saw h.. alive on April 19th 1945

Immediate cause of death	DURATION
Chronic Nephritis	
Due to	
Due to	
Other conditions: Myocarditis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: William Emrick M. D. ~~or other~~

Address: Nelson - Md Date signed April 20th

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04308

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico
County
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred: 610 E. Church street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 610 E. Church St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ernest James Ellis

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sallie Ellen Ellis
6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): Dec. 12 1865

8. AGE:

Years	Months	Days	If less than one day
79	4	28	hrs. min.

9. Birthplace: Salisbury Md.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Laborer

FATHER
12. Name: George Ellis
13. Birthplace: Salisbury Md.

MOTHER
14. Maiden name: Charlotte Jenkins
15. Birthplace: Maryland

16. Informant: Mrs. Sallie E. Ellis
Address: 610 E. Church St. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 2-1945 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland

18. Funeral director: Hall and Son-Walter P. Hall
Address: Salisbury Maryland

19. 5/2 1945 Gabriel E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 29 1945 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/23 1945 to 4/29 1945 and that I last saw him alive on 4/28 1945

Immediate cause of death	DURATION
Lobar Pneumonia	3 days
Due to: Senility	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edward Tilden M.D.
M. D. or other
Address: Salisbury Md. Date signed: 5/1/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

04399

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution? two weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Wicomico

City or town Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. no
(If rural, give LOCATION)

2.(a) If veteran, name war no

3.(a) FULL NAME Homer J. Barlow

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a.a.	Married

6.(b) Name of husband or wife Martha Barlow

6.(c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.) about 1917

8. AGE: Years about 28 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Salisbury Md
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Same as above

FATHER
12. Name Charles Barlow
13. Birthplace Pittsville Md

MOTHER
14. Maiden name Bertha Hearn
15. Birthplace Parsonsburg Md

16. Informant Charles Barlow
Address Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/30/1945 (month) (day) (year)

Cemetery or crematory Glenwood

Location Parsonsburg Md

18. Funeral director James R. Stewart

Address Salisbury Md

19. 4/30/1945 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 27 1945, at 5-43 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/10 1945, to 4/27 1945

and that I last saw h... alive on 4/27 1945

Immediate cause of death Chronic Nephritis — DURATION 6 mos

Due to

Due to

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations none ... Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE Stevens Hanson, M.D.
M. D. or other

Address Salisbury, Md Date signed 5/2/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04310

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury 2nd
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 2 months
Hospital, Institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DEACEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury 2nd
(If outside city or town limits, write RURAL and give nearest town)
Street No. 603 Moore St
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: William Gaines

3.(b) Social Security Number: Cant be found

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a.a.	Single

6.(b) Name of husband or wife: no
6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): Jan 22 1922

8. AGE: Years 23 | Months 3 | Days 6 | If less than one day: hrs. min.

9. Birthplace: Columbia Near Laurel Del (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Same as above
12. Name of FATHER: Harrison Gaines
13. Birthplace of FATHER: Columbia near Laurel Del
14. Maiden name of MOTHER: Mattie Truitt
15. Birthplace of MOTHER: Clossenburg Near Laurel Del
16. Informant: Mable White
Address: Salisbury Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 1 1943 (month) (day) (year)
Cemetery or crematory: Pelon
Location: Near Delmar Del
18. Funeral director: James D. Stewart
Address: Salisbury Md
19. (Date rec'd by registrar) 5/1/1943 Registrar: Clarence E. Johnson

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 28, 1943 at 5:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28, 1943 to April 28, 1943 and that I last saw deceased alive April 28, 1943

Immediate cause of death	DURATION
Due to: Pulmonary TBC	5 mos
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: G. H. Lemby M.D. (M. D. or other)
Address: Salisbury Md Date signed: 4/28/43

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04311

Reg. Dist. No. 323

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 years

Hospital, institution, or street address where death occurred: Memorial General Hospital

How long in hospital or institution? 2 month 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 132 W. College ave

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME: William W Lavin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Nellie L. Lavin

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Sept 24, 1889

8. AGE:

Years	Months	Days	If less than one day
55	6	28	...hrs. ...min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Moving & Storage

11. Industry or business

FATHER — 12. Name: Thomas Lavin

13. Birthplace: Baltimore, Md

MOTHER — 14. Maiden name: Florence Lodden

15. Birthplace: Baltimore, Md

16. Informant: Mrs W. W. Lavin

Address: Salisbury, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/25/45 (month) (day) (year)

Cemetery or crematory: Parsons Cemetery

Location: Salisbury Md

18. Funeral director: Hill & Johnson Co

Address: Salisbury, Md

19. (Date rec'd by registrar) 4/25/45 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22, 1945 at 4 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19... to 4-22 19 45

and that I last saw him alive on April 22 19 45

Immediate cause of death	DURATION
amebic abscess of liver	9 mos
Due to: amoebic dysentery	15 mos
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: amebic abscess of liver. Date of op. 4-25-45 (2-25-45)

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: LaRedenbo MD M. D. or other

Address: Salisbury Md Date signed 4/22/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

04312

Reg. Dist. No. 333

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 58 years
Hospital, Institution, or street address where death occurred: 1001 East Division St.
How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1001 East Division St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME Marguerite Teresa Grier

3.(b) Social Security Number ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Fred A. Grier, Sr. ✓
6.(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) March 6, 1863.

8. AGE: Years 81 | Months 1 | Days 4 | If less than one day ..... hrs. ..... min.

9. Birthplace: Wilmington, Del. (Town, county, and state)
10. Usual occupation: At Home
11. Industry or business ✓
FATHER 12. Name: John G. Peterbaugh
13. Birthplace: Baden, Germany.
MOTHER 14. Maiden name: Marie Pabst
15. Birthplace: Baden, Germany.
16. Informant: Fred A. Grier, Jr.
Address: Salisbury, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/10/45 (month) (day) (year)
Cemetery or crematory: Parsons
Location: Salisbury, Md.
18. Funeral director: De Vilbiss & Leonard Co.
Address: Salisbury, Md.
19. 4/10/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8, 1945 at 9 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/27/45 to April 8 1945
and that I last saw h. alive on April 7 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	16 days
Due to: Hypertension	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Howard R. Mann M. D. or other
Address: Salisbury, Md. Date signed: 4/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

04313

Reg. Dist. No. 24336

1. PLACE OF DEATH:

County: Wicomico

City or town: Delmar Md Dist

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Delmar Md Dist

(If outside city or town limits, write RURAL and give nearest town)

Street No.: no

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Alberta F Gandy

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	a.a.	married

6.(b) Name of husband or wife: Jerome Gandy

6.(c) If alive, give age: Don't know years

7. Birth date of deceased (mo., day, yr.): Feb 5 about 1878

8. AGE: Years 67 | Months — | Days — | If less than one day ... hrs. ... min.

9. Birthplace: Mardella Springs Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Same as above

FATHER

12. Name: James Elzy

13. Birthplace: Mardella Springs md

MOTHER

14. Maiden name: Mary E Dunton

15. Birthplace: Mardella Springs Md

16. Informant: Mrs Lillian Gandy Parker

Address: Delmar Del.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 7 (month) (day) 1944 (year)

Cemetery or crematory: Union

Location: Delmar Md Dist

18. Funeral director: James P Stewart

Address: Salisbury Md

19. 11-9-1944 (Date rec'd by registrar) Harry E Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 5 1944, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 2 1944 to April 5 1944

and that I last saw h. on alive on April 5 1944

Immediate cause of death	DURATION
Carcinoma Stomach with met. to liver Pericarditis	4 days
Due to: Hypertension + arteriosclerosis	4 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: J H Lynch M. D. or other

Address: Delmar Del. Date signed: 11-8-1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-e)

CERTIFICATE OF DEATH

04314

Reg. Diat. No. 335

1. PLACE OF DEATH:
County Worcester
City or town Sharptown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 1/2 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants give residence of mother)
State Md. County Worcester
City or town Sharptown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Maggie L. Griffith

3.(b) Social Security Number

4. Sex F
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Guernie Griffith
6.(c) If alive, give age 57 years
7. Birth date of deceased (mo., day, yr.) May 23 1887
8. AGE: Years 57 Months 11 Days 4 If less than one day hrs. min.
9. Birthplace Dorchester Md (Town, county, and state)
10. Usual occupation House work
11. Industry or business

FATHER
12. Name Isaac Fennimore
13. Birthplace Md

MOTHER
14. Maiden name Lovey Halston
15. Birthplace Md

16. Informant Guernie Griffith
Address Sharptown

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 19 1945 (month) (day) (year)
Cemetery or crematory Freemans
Location Sharptown
18. Funeral director Groundmyer Bros
Address Sharptown

19. Apr 19 1945 (Date rec'd by registrar) Walter H. Mann Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1945 at 4 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 1943 to April 18 1945
and that I last saw h.. alive on April 18 1945

	DURATION
Immediate cause of death Carcinoma of Stomach	18 Months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. D. Kuhlman M. D.
M. D. or other
Address Sharptown Md Date signed April 19 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Insley

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (468)

04315

CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK: Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred: 409 E. Vine street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 409 E. Vine st. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Wilmer Linwood Hammond
3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Bessie Hammond
6.(c) If alive, give age: 53 years
7. Birth date of deceased (mo., day, yr.): June 1 - 1891
8. AGE: Years 53 Months 10 Days 19 If less than one day ... hrs. ... min.
9. Birthplace: R.D. #3 Salisbury Md. (Town, county, and state)
10. Usual occupation: Chauffeur
11. Industry or business: Md. State Roads Dept.
FATHER 12. Name: Wm James Hammond
13. Birthplace: R.D. #3 Salisbury Md
MOTHER 14. Maiden name: Rebecca Bethards
15. Birthplace: Wico. Co. Maryland
16. Informant: Mrs. Bessie Hammond
Address: 409. E. Vine st. Salisbury. Md.
17. Burial (Burial, cremation, or removal, Which?) Date thereof: Apr. 23-45 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland
18. Funeral director: Holloway by Walter R. Holloway
Address: Salisbury Maryland.
19. 4/23, 1945 Harriet E. Johnson, Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20th 1945, at 5 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 2. 1944, to April 20 1945, and that I last saw h/im alive on April 12 1945

Immediate cause of death	DURATION
Carcinoma Stomach	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: [signature] M.D. or other
Address: Salisbury, Md. Date signed 4-21-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51-6)

04316

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 5 days 15 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Del. County Sussex

City or town Laurel R.D. (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mr. Robert H. Hearn

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Widower

6.(b) Name of husband or wife Lottie E. Hearn

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1866

8. AGE: Years	Months	Days	If less than one day
78	8	25	hrs. min.

9. Birthplace Del. U.S.A. (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER 12. Name	Wm. Thos. Hearn
FATHER 13. Birthplace	Del. U.S.A.
MOTHER 14. Maiden name	Lavenia Packer
MOTHER 15. Birthplace	Del. U.S.A.

16. Informant Mrs. Fenney Freeman

Address Laurel, Del. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 8-45 (month) (day) (year)

Cemetery or crematory St. Marks Cemetery

Location Laurel, Del. R.D.

18. Funeral director Harvey Williamson

Address Bridgeville, Md.

19. 4-7-45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 19 45, at 12 05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 31 19 45, to April 6 19 45

and that I last saw h) alive on April 1 19 45

Immediate cause of death	DURATION
Cancer of Prostate	3 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. A. Redmond M.D. M. D. or other

Address Salisbury, Md. Date signed 4/6/45

M

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VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

04317

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution? 24 Mons

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Salem
(If outside city or town limits, write RURAL and give nearest town)

Street No. R F D # 1
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Holloway, Baby Girl

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 29, 1945

8. AGE: Years | Months | Days | If less than one day ..... hrs. 24 min.

9. Birthplace Salisbury, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Joseph Gullette

13. Birthplace Wicomico County, Md.

MOTHER 14. Maiden name Elizabeth Ellen Holloway

15. Birthplace Salem (Wic. Co) Md.

16. Informant Elizabeth Ellen Holloway

Address Quantico, Md.

17. Cremation (Burial, cremation, or removal Which?) Date thereof April 30 1945 (month) (day) (year)

Cemetery or crematory Peninsula General Hospital

Location South Division Street, Salisbury

18. Funeral director Peninsula General Hospital

Address Salisbury, Md.

19. 4/30/45 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1945, at 11:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Procedure	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Glenn A. Tudor M. D. or other

Address Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: In items 9 to 15 write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04318

Reg. Diat. No. 335

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians—please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Sharptown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Sharptown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary H. Hutchings

3.(b) Social Security Number

4. Sex: F
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Aug 19 1865
8. AGE: Years: 79 Months: 7 Days: 25 If less than one day: hrs. min.
9. Birthplace: Wicomico Md (Town, county, and state)
10. Usual occupation: House work
11. Industry or business:
FATHER 12. Name: William T. English
13. Birthplace: Md
MOTHER 14. Maiden name: Sarah Hastings
15. Birthplace: Del
16. Informant: Elmer H. Hutchings
Address: Sharptown
17. Buried (Burial, cremation, or removal. Which?) Date thereof 4 15 1945 (month) (day) (year)
Cemetery or crematory: Taylor
Location: Sharptown
18. Funeral director: Engleman Bros
Address: Sharptown Md
19. 4/12 1945 (Date rec'd by registrar) Walter S. Mann Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11 1945 at 2.9 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1936 to April 11 1945 and that I last saw h.. alive on April 11 1945

Immediate cause of death: Chronic Valvular Disease — DURATION: 9 yrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. S. Kuhlman M. D. or other
Address: Sharptown Md Date signed 4/13/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04319

CERTIFICATE OF DEATH

Reg. Diat. No. 339

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, Institution, or street address where death occurred: 308 Newton St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 308 Newton St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Margaret Davis Ingersall

3.(b) Social Security Number: 214-10-7082

4. Sex: Female | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: L. Herald Ingersall

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): Jan 12, 1895

8. AGE: Years: 50 | Months: 2 | Days: 21 | If less than one day: hrs. min.

9. Birthplace: Salisbury Wicomico co. Md
(Town, county, and state)

10. Usual occupation: Saleslady

11. Industry or business: Ladies Ready to Wear

MOTHER
12. Name: Joseph C. Davis
13. Birthplace: Wicomico co. Md

FATHER
14. Maiden name: Nancy E. Baker
15. Birthplace: W. Somerset co. Md

16. Informant: L. Herald Ingersall
Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/4/45 (month) (day) (year)
Cemetery or crematory: Parsons cemetery
Location: Salisbury Md

18. Funeral director: W. Hill Johnson co
Address: Salisbury Md

19. 4/4 1945 Harriet E. Johnson Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2, 1945 at 7 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28 1945 to April 2 1945 and that I last saw h alive on April 2 1945

Immediate cause of death	DURATION
Coronary Thrombosis	Hours
Due to	
Due to	
Other conditions: Uterine Fibroid	

(Include pregnancy within 3 months of death)

Major findings of operations: Fibroid

Date of op. 3/30/45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Salisbury Date signed 4/5/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-0)

04320

CERTIFICATE OF DEATH

Reg. Dist. No. 339

1. PLACE OF DEATH: Wicomico
County
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred: R.D. #1.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. #1.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Clarence Purnell Johnson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: May Pearl Johnson
6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.): April 1- 1880

8. AGE:

Years	Months	Days	If less than one day
65	0	3	hrs. min.

9. Birthplace: Wicomico Co. RD. Salisbury Md
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: John E. Johnson
13. Birthplace: Wicomico Co. Md.

MOTHER
14. Maiden name: Maggie McAllister
15. Birthplace: Wicomico Co. Maryland

16. Informant: Mrs. May P. Johnson
Address: R.D. #1. Salisbury Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 7-1945 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury, Maryland
18. Funeral director: Holloway & Walter P. Holloway
Address: Salisbury Md.

19. 4/7/45 (Date received by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4th 1945 at 11.15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 20 1945 to Apr. 4 1945 and that I last saw h.. alive on Apr. 4 1945

Immediate cause of death	DURATION
Chr. Valv. Heart	6 mo
Due to Chr. Inst. Nephritis	10 mo
Due to Arter. Sclerosis	7 yrs
Other conditions Bronchitis	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. O. Davis M.D.
M. D. or other
Address Salisbury Md Date signed 4-5-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Gray

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04321

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico
County
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months
Hospital, institution, or street address where death occurred: 102 W. Phila. Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 102 W. Phila Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James Monroe Maddox

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widower
6.(b) Name of husband or wife: Theodosia Maddox
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): July 17 - 1859
8. AGE: Years 85 Months 9 Days 3 If less than one day hrs. min.
9. Birthplace: Sussex Co. R.D. Delmar Del
(Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business
FATHER 12. Name: James Maddox
13. Birthplace: Sussex Co. Delaware
MOTHER 14. Maiden name: Mary Dale
15. Birthplace: Sussex Co. Delaware
16. Informant: Mrs. Sadie Lecates
Address 102 W. Phila. Ave. Salisbury Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 22-1945 (month) (day) (year)
Cemetery or crematory Melson Church Cem
Location R.D. Delmar Maryland
18. Funeral director Holloway & Co. Walter R. Holloway
Address Salisbury Maryland
19. 4/23/45 (Date rec'd by registrar) 1945 Clarice E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 - 1945 at 1:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 30 1945 to April 20 1945
and that I last saw h... alive on April 20 1945
Immediate cause of death: Cerebral Apoplexy — DURATION
Due to: Arterio Sclerosis
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jno D Gray M.D.
M. D. or other
Address 324 Camden Ave Salisbury Md. Date signed 4/24/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1914)

04322

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 years
Hospital, institution, or street address where death occurred: 309 Fitzwater
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants, give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 309 Fitzwater St (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Thomas E. McCready
3. (b) Social Security Number: 212-12-3022

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sarah S. McCready
6.(c) If alive, give age: 71 years
7. Birth date of deceased (mo., day, yr.): Sept 3 1865

8. AGE: Years 79 | Months 7 | Days 12 | If less than one day: hrs. min.

9. Birthplace: Sanford, Accomac Co, Va (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business:
MOTHER FATHER 12. Name: William McCready
13. Birthplace: Sanford, Va
MOTHER 14. Maiden name: Susie Marshall
15. Birthplace: Sanford Va.
16. Informant: Mrs Sarah McCready
Address: Salisbury, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/17/45 (month) (day) (year)
Cemetery or crematory: Pidgeon Cemetery
Location: Sanford, Va.
18. Funeral director: The Hill & Johnson Co
Address: Salisbury, Md
19. (Date rec'd by registrar) 4/17/45 Harriet E. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15 1945, at 6 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-1 1945 to 4-15 1945 and that I last saw h... alive on 4-1 1945

Immediate cause of death	DURATION
Cardio-vascular	
Due to: Renal Disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas L. G. Leslie M. D. or other
Address: Salisbury, Md Date signed: 4-16-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

04323

Reg. Dist. No. 3 2 5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Sharptown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Sharptown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Daniel J. Mitchell

3.(b) Social Security Number: 220-07-55-01

4. Sex: M | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 29 1859

8. AGE: Years: 86 | Months: 2 | Days: 8 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Sussex, Del.
(Town, county, and state)

10. Usual occupation: Retired Ship Carpenter

11. Industry or business:

FATHER
12. Name: Daniel J. Mitchell
13. Birthplace: Del

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Martha Mitchell
Address: Sharptown

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 7 1945 (month) (day) (year)
Cemetery or crematory: Taylor
Location: Sharptown

18. Funeral director: Graham Bros
Address: Sharptown

19. 4-7-45 1945 Walter J. Mann
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr 5 1945 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1941 to Apr 5 1945 and that I last saw h.. alive on Apr 5 1945

Immediate cause of death: Coronary Occlusion — DURATION: 3 days

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: H. S. Kuhlman M. D. or other
Address: Sharptown Md. Date signed: Apr 6 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-6)

CERTIFICATE OF DEATH

04324

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 8 hrs 35 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Worcester

City or town Near Pocomoke

(If outside city or town limits, write RURAL and give nearest town)

Street No. no

(If rural, give LOCATION)

2.(a) If veteran, name war Don't know ✓

3. (a) FULL NAME Allen Monday

3. (b) Social Security Number Don't know

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Don't know

6.(b) Name of husband or wife no 6.(c) If alive, give age no years

7. Birth date of deceased (mo., day, yr.) about 1876

8. AGE: Years	Months	Days	If less than one day
about 69			hrs. min.

9. Birthplace Don't know (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Same

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Peninsula General Hospital

Address Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 26-1945 (month) (day) (year)

Cemetery or crematory Public

Location Salisbury Md

18. Funeral director James F. Stewart

Address Salisbury Md

19. 4/26/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1945, at 6:35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 24 1945 to Apr. 24 1945 and that I last saw him alive on Apr. 24 1945

Immediate cause of death	DURATION
Chronic Myocard. Dis	
Due to Aortic & Mitral	
Due to Insufficiency	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results confirmed above findings

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Rivers Hanson, M.D.

M. D. or other

Address Salisbury, Md Date signed 4-24-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

. 2411 N. Charles St., Baltimore

04325

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico
County
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred: 605 S. Division street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED.
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 605 S. Division St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Eva May Parker

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John Edward Parker
6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Nov. 25-1879

8. AGE: Years	Months	Days	If less than one day
65	5	1	hrs. min.

9. Birthplace: Worcester Co. Boy Iron Md.
(Town, county, and state)
10. Usual occupation: Home imp
11. Industry or business:

FATHER
12. Name: John Taylor Richardson
13. Birthplace: Worcester Co. Boy Iron Md.

MOTHER
14. Maiden name: Mary E. Scott
15. Birthplace: Worcester Co. Green Run Md

16. Informant: Mr. John E. Parker
Address: 605 S. Div. St. Salisbury Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof April 28-45 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Md.

18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Maryland

19. 4/28/45 19 46 (Date rec'd by registrar) Hazel D. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26th 19 45 at 405p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22 19 45 to April 26 19 45 and that I last saw h[illegible] alive on April 26 19 45

Immediate cause of death: Cerebral Hemorrhage — DURATION: 4 days
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Floyd A. Insley M. D. or other
Address: Salisbury Md. Date signed 4-28-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1915)

CERTIFICATE OF DEATH

04326

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Mo 3 Wks 2 Days
Hospital, institution, or street address where death occurred: P. G. Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Pocomoke City Rural (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: No ✓

3.(a) FULL NAME: Cordelia Anna Payne

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Eugene Payne
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 2 / 1863

8. AGE:

Years	Months	Days	If less than one day
81	4	14	hrs. min.

9. Birthplace: Pocomoke City Worcester MD (Town, county, and state)
10. Usual occupation: Retired Merchant
11. Industry or business: General Store
FATHER 12. Name: Thomas Jones
13. Birthplace: Maryland
MOTHER 14. Maiden name: Caroline S. Hancock
15. Birthplace: Maryland
16. Informant: Mrs. O. M. Jones
Address: Snow Hill, MD
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 18 45 (month) (day) (year)
Cemetery or crematory: Riverview
Location: Snow Hill, Md
18. Funeral director: Dearne & Dunning
Address: Snow Hill, Md
19. 4/18/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16 19 45, at 1:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 22 19 45, to April 16 19 45
and that I last saw her alive on April 16 19 45

	DURATION
Immediate cause of death: Acute pulmonary edema	2 wks
Due to: Cardiac failure	4 mos
Due to: Hypertensive Cardio-vascular-renal syndrome	?
Other conditions: senility (Include pregnancy within 3 months of death)	

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert L. LaMar, M.D. M. D. or other
Address: Snow Hill Date signed: 4-17-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

04327

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 weeks

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 6 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Rural Pocomoke Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Pilchard, Mrs Susan

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	✓

6.(b) Name of husband or wife: Mr. Charlie Pilchard

6.(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.): June 7, 1877

8. AGE:

Years	Months	Days	If less than one day
67	10	22	..... hrs. ..... min.

9. Birthplace: Accomac Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

MOTHER FATHER

12. Name: William T. Justice

13. Birthplace: Va

14. Maiden name: Sallie Dix

15. Birthplace: Va

16. Informant: Mr Walter Pilchard

Address: Pocomoke City Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 1-1945 (month) (day) (year)

Cemetery or crematory: Baptist Cemetery

Location: Rural Pocomoke Md.

18. Funeral director: Margaretta Webster

Address: Pocomoke City Md.

19. 5/1/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-29 1945 at 1.35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-16 1945 to 4-29 1945 and that I last saw h e ✓ alive on 4-29 1945

Immediate cause of death	DURATION
Carcinoma of Rectum	6 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of rectum found Date of op. (3-18-45 (3-31-45

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE L A Rademaker M.D.

M. D. or other

Address Salisbury Md. Date signed 4/29/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04328

CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: Peninsula General Hosp.

How long in hospital or institution? 3 days 6 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Delaware County: Sussex

City or town: Delmar (If outside city or town limits, write RURAL and give nearest town)

Street No.: R.F.D. #1 (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Oswald Robbins

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Infant.

6.(b) Name of husband or wife: /

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 9, 1944

8. AGE:

Years	Months	Days	If less than one day
	5	15	..... hrs. ..... min.

9. Birthplace: Williamsville, Del. (Town, county, and state)

10. Usual occupation: /

11. Industry or business

FATHER — 12. Name: Oswald William Robbins

FATHER — 13. Birthplace: Exmore, Virginia

MOTHER — 14. Maiden name: Mary Mae Morris

MOTHER — 15. Birthplace: Thousands of Virginia

16. Informant: Oswald William Robbins

Address: Delmarville, Delaware Route 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 25 1945 (month) (day) (year)

Cemetery or crematory: Lynch Cemetery

Location: Salisbury, Md.

18. Funeral director: W. Pasha Watson

Address: Salisbury, Md.

19. 4/26/45 (Date rec'd by registrar) Harriet E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 24, 1945, at 2 A M

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Apr. 20 1944, to Apr. 24 1945 and that I last saw h/ive on Apr. 24 1945

Immediate cause of death: Influenzal Meningitis — DURATION

Due to: —

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.:

Autopsy results: Confirmed diagnosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Rivers Hanson, M.D. M. D. or other

Address: Salisbury, Md. Date signed: 4/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 7-0

D4329

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. R 8 Box
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Carlton E. Robertson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed

6.(b) Name of husband or wife: Mattie H. Robertson
6.(c) If living, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 9, 1879

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
65	9	7		

9. Birthplace: Clara Wicomico Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: J. W. T. Robertson
13. Birthplace: Clara Md.

MOTHER
14. Maiden name: Caroline Collier
15. Birthplace: Clara Md.

16. Informant: Mrs. Ruby Wescott
Address: Salisbury Md.

17. Buried (Burial, cremation, or removal, which) Date thereof 4/19/45 (month) (day) (year)
Cemetery or crematory: Robertson Cemetery
Location: Clara Md.

18. Funeral director: David E. Wescott
Address: Hebron Md.

19. April 18 1945 Mrs J. M. Walker
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION (Approximate)

20. DATE OF DEATH: April 16 1945 at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 19.. to April 16 1945
and that I last saw him alive on April 1 1945

Immediate cause of death	DURATION
Chronic myocarditis	3 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. Brownmiller M.D.
M. D. or other
Address: Salisbury Md. Date signed: Apr 17

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

T04330

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 303

VS A15 (1) MARGIN RESERVED FOR BINDING (2) PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Weeks

Hospital, institution, or street address where death occurred: U.S. Hospital

How long in hospital or institution? 5 Wks.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Maudela Springs Md. (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Frederic Schultz

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife: Emma Schultz

6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): June 22 1864

8. AGE: Years	Months	Days	If less than one day
80	10	6	...hrs. ...min.

9. Birthplace: Stettin, Germany (Town, county, and state)

10. Usual occupation: Farming

11. Industry or business

FATHER 12. Name: unknown

13. Birthplace

MOTHER 14. Maiden name: unknown

15. Birthplace

16. Informant: Mrs. Emma Schultz

Address: Maudela Springs, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/2/45 (month) (day) (year)

Cemetery or crematory: Maudela Springs, Md.

Location:

18. Funeral director: David K. Messick

Address: Hebron, Md.

19. 5/6 1945 Maggie E. Johnson Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 28, 1945, at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 4 1945, to April 28 1945

and that I last saw h... alive on April 28 1945

Immediate cause of death	DURATION
Diabetes gangrene	2 weeks
left foot	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Diabetic Gangrene of left foot Date of op. 4-10-45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [illegible] M D

M. D. or other

Address: Salisbury, Md. Date signed 5/1/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04331

CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred: P.B. Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For known infants give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 317 Wicomico Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Charles Peter Sturgis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Laura Avery Sturgis
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): March 20-1878

8. AGE:

Years	Months	Days	If less than one day
67	1	2	hrs. min.

9. Birthplace: R.D. Delmar, Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:

FATHER
12. Name: Charles Sturgis
13. Birthplace: R.D. Delmar, Md.

MOTHER
14. Maiden name: Mary Parsons
15. Birthplace: R.D. Delmar, Md.

16. Informant: Mrs. Martha Lemon
Address: 314 Martin St. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 24-45 (month) (day) (year)
Cemetery or crematory: M.E. Cemetery
Location: Delmar Delaware

18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Maryland.

19. 4/23/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22nd 1945 at 5:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 20 1945 to Apr. 22 1945 and that I last saw h... alive on Apr. 22 1945

Immediate cause of death	DURATION
Coronary Thrombosis	2 weeks
Due to, Carcinoma of Stomach	9 mos
Due to, Senility	7 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H.D. Gay M.D.
M. D. or other
Address: Salisbury Md. Date signed 4-24-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04332

CERTIFICATE OF DEATH

Reg. Dist. No. 331

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Quantico (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Quantico (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Asbury Washington Taylor

3.(b) Social Security Number:

4. Sex: M.
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: —
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): June 15, 1879
8. AGE: Years: 65 Months: 9 Days: 24 If less than one day: ..... hrs. ..... min.
9. Birthplace: Quantico Wicomico Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Farm
FATHER 12. Name: Andrew Taylor
FATHER 13. Birthplace: Rockawalkin Md.
MOTHER 14. Maiden name: Ella F. Smith
MOTHER 15. Birthplace: Maryland
16. Informant: Carlton Taylor
Address: Quantico Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/10/45 (month) (day) (year)
Cemetery or crematory: Quantico Cemetery
Location: Quantico, Md.
18. Funeral director: Mrs. C. Messick & Sons
Address: Hebron, Md.
19. April 10 1945 Mrs J. M. Wallace (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 8, 1945 at 8:05 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 8 1945 to April 8 1945 and that I last saw h.. alive on April 8 1945

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions Arteriosclerosis	

(Includo pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: William Ewell M. D. or other
Address: Helen. Md. Date signed April 9, 45